ORANGE BOARD OF EDUCATION
EARLY CHILDHOOD REGISTRATION FORM

(OFFICINA DE NINEZ TEMPRANA – FORMA DE MATRICULACIÓN) (FÒMILÈ ENSKRIPSYON)

ECE OFFICE USE ONLY:		
ID#		
Home School		
Preschool		
Languages	Primary	Home
Family Code		

DATE ____________
(FECHA) (DAT)

ABOUT THE CHILD *(Información de niño) (Enfòmasyon sou timoun nan)*

Name on Birth Certificate (*Nombre en Acto de Nacimiento*) (*Non ki sou batistè ti moun nan*):

____________ ____________ ____________

First (*Primer*)(*Prenon*) Middle (*Segundo*) (*Dezyèm prenon*) Last (*Apellido*) (*Siyati*)

Child's Date of Birth ____________
(*Fecha de nacimiento*) (*Dat Timoun nan fèt*)

Age:____________
(*Edad*) (*Laj timoun nan*)

Sex: M _____F______
(*Sexo*) (*Sèks*)

Ethnicity:
(*Etnia*) (*Ras*)

White______
(*Blanco*) (*Blan*)

Black______
(*Moreno)(Nwa)*)

Hispanic______
(*Hispano*)(*Panyòl)*

Bi-racial______
(Bi-racial) (Bi-rasyal)

Country of Birth____________
(*Pais de nacimiento*) (*Peyi kote timoun nan fèt*)

City of Birth____________
(*Ciudad de nacimiento*) (*Vil Kote timoun nan fèt*)

Date of U.S. Entry ____________
(Fecha de entrada a Los Estados Unido) (États-Unis Date d'entrée)

Address:____________
(*Dirección*) (*Adrès)*

Home phone # ____________
(*Número de telefono de casa) (Nimewo telefòn lakay)*

Cell# ____________
(*Número cellular*) (*Nimewo telefòn selilè)*

Mother/Guardian Name____________
(Nombre de Madre/ Guardián) (Non manman / Moun ki responsab ti moun nan)

Home Address:____________
(*Dirección*) (*Adrès lakay)*

Home phone # ____________
(*Número de telefono de casa*) (*Nimewo telefòn lakay)*

Cell# ____________
(*Número cellular*) (*Nimewo telefòn selilè)*

Mother's Email Address:

Employer Name and Address (*Nombre de Empleador y Dirección*) (*Non ak adrès kote wap travay)*

____

____

Employer's Phone #____________
(*Número de telefono de Empleador*) (*Nimewo Telefòn kote wap travay)*

Occupation____________
(*Ocupación*) (*Pwofesyon w)*

☐ Work Full-Time
(*Trabajas Tiempo completo*)
(Travay a tan plen)

☐ Work Part-Time
(*Trabajas Tiempo medio*)
(Travay a tan pasyèl)

☐ Work Seasonal
(*Trabajas estacional*)
(Travay sezonye)

Father/Guardian Name____
(Nombre de Padre/ Guardián) (Non papa/Moun ki responsab ti moun nan)

Home Address:____
(Dirección)(Adrès lakay)

Home phone # ______________________________ Cell# ______________________________
(Número de telefono de casa) (Nimewo telefòn lakay) *(Numero cellular) (Nimewo telefon selile)*

Father's Email Address:

Employer Name and Address *(Nombre de Empleador y Dirección) (Non ak adrès kote wap travay)*

____

____

Employer's Phone #___________________________ Occupation ___________________________
(Número de telefono de Empleador) (Nimewo Telefòn kote wap travay) *(Ocupación) (Pwofesyon w)*

☐ Work Full-Time *(Trabajas Tiempo completo) (Travay a tan plen)*

☐ Work Part-Time *(Trabajas Tiempo medio) (Travay a tan pasyèl)*

☐ Work Seasonal *(Trabajas estacional) (Travay sezonye)*

FAMILY HISTORY *(Historia Familiar)(Enfòmasyon medical sou ti moun nan)*:

What kind of Health Insurance does the child have? *(¿Qué clase de Seguro Médico tiene el niño?)(Ki kategori asirans medikal ke ti moun nan genyen)*

______ Private or employment based *(Privado o del Empleador)(Asirans prive ou byen asirans travay)*

______ Medicaid *(Medicaid)*

______ New Jersey Family Care *(NJ Family Care)*

______ Charity Care *(Cuidado de Caridad)*

______ Uninsured *(No tiene seguro)(San asirans)*

Does the child have any chronic medical problems, special needs, or disabilities? Yes______ No______
(¿Tiene su niño algún problema médico crónico, ó necesidad especial, ó es incapacitado?) *(Sí) (Wi)* *(No) (Non)*
(Eske ti moun nan soufri ak yon maladi ke l toujou genyen, bezwen yon asistans espesyal oswa andikape)
If Yes, describe *(Describir si es sí)(Siw reponn wi, bay plis esplikasyon)*:

____

____

Has the child been in an Early Intervention Program? Yes________ No__________
(¿Ha estado el niño en un Programa de Intervención Temprana?) *(Sí) (Wi)* *(No) (Non)*
(Eske ti moun nan te swiv yon pwogram entèvensyon bonè)

Have there been any changes in your life or the child's life in the past six months? Yes_____ No______
(¿Ha habido cualquier cambio en su vida o en la vida del niño en los ultimos seis meses?) *(Sí) (Wi)* *(No) (Non)*
(Eske gen yon chanjman ki fèt nan vi pa w oswa nan vi ti moun nan pandan sis dènye mwa yo)
If Yes, describe (Describir si es sí)(Si w reponn wi, bay plis esplikasyon):

____

____

Child lives with and they have legal custody (**Documentation of custody needed**)
(*Con quien vive el niño y si tienen custodia legal* (***Documentación legal necesaria***)
(Ak kiyès moun ti moun nan ap viv, eske moun saa gen otorizasyon lalwa pou l fè sa / Fok ou bay dokiman ki pwouve sa)

_____Mother & Father (*Madre y Padre*) *(Manman ak Papa)*
_____Mother ONLY (*SoloMadre*) *(Manman sèlman)*
_____Father ONLY (*SoloPadre*) *(Papa sèman)*
_____Guardian (*Guardián*) *(Moun ki responsab la)*

_____Adpotive Parent(s) (*Padres Adoptivos*) *(Paran adoptif)*
_____Foster Parent(s) (*Padres temporales*) *(Paran ti moun nan pou yon ti bout tan)*

What methods of transportation do your household members have convenient access to/from home?
(¿Qué métodos de transporte tienen los miembros de su hogar par air y venire de casa?)
(Ki mwayen deplasman moun ki lakay ou itilize pou yo rantre ak sòti lakay ou)

_____Personal Car/automobile (*Coche/Automóvil personal*) *(machin prive/Otomobil)*

_____Public Transportation/mass transit-bus, rail (*Transporte público/el autobus, tren*) *(Machin piblik/Bis/Tren)*

_____No convenient access to car or public transportation (*Ningún acceso a transporte personal ó público)(Pa gen machin prive ou byen paka pran machin piblik)*

Including yourself and the child, how many people (adults and children) are there in your family that reside with you? ________
(¿Incluyendose y al niño, cuántas personas más (adultos y niños) residen en su hogar?)
(Konbyen moun (gran moun ak ti moun) ki nan fanmi w kap viv ak ou / Konte tèt pa w ak ti moun nan tou)

Including your child, how many of these family members are children under the age of 18? ____________
(*¿Incluyendo a su niño, cuántos de estos miembros de familia son menores de 18 años?*)
(Konbyen moun ki nan fanmi w kap viv lakay ou e ki poko gen 18 tan / Konte ti moun nan tou)

Name of Adults Residing in the Home (*Los nombres de los Adultos que Residen en el Hogar*) *(Non tout moun ki gen plis ke 18 tan kap viv nan kay la)*	**Relationship to Child** (*Relación al Niño*) *(Kisa yo ye pou timoun nan)*

Name of the other children residing in the home (*Nombre de los otros niños que residen en su hogar*) *(Non lòt ti moun kap viv nan kay la)*	**Relationship to your Child** (*Relación a su Niño*) *(Kisa yo ye pou ti moun nan)*	**Age** (*Edad*) *(Laj)*	**School Attending** (*Escuela asistiendo*) *(Nan ki lekol yo te ale)*

In the past, has your child been in daycare? ______ Yes ______ No
(¿En el pasado, ha participado su niño en guardería infantil?) *(Sí)* *(No)*
(Nan ane ki pase yo, eske ti moun nan te nan yon gadri pou ti moun) *(Wi)* *(Non)*

If Yes, where? ______________________ How long? ______________________
(¿Dónde?) *(¿Cuánto tiempo?)*
(Si w reponn wi, ki kote ?) *(Pandan konbyen tan ?)*

Preschool? ______ Yes ______ No Where? ______________________ How long? __________
(¿Preescolar?) *(Sí)* *(No)* *(¿Dónde?)* *(¿Cuánto tiempo?)*
(Preskolè) *(Wi)* *(Non)* *(Ki kote)* *(Pandan konbyen tan)*

________At home with Parent? ________At home with Relative ________At home with babysitter?
(¿En casa con Padre?) *(¿En casa con Pariente?)* *(¿En casa con canguro?)*
(Lakay manman ak papa) *(Lakay yon fanmi)* *(Ak yon moun ki konn okipe ti moun)*

At Home Activities: (*Actividades del Hogar*)*(Kisa ti moun nan fè kòm aktivite lè l lakay li)*

Activity (***Actividades***)	**Daily** *(Diario)(Chak jou)*	**Rarely** *(Raramente)(yon lè konsa)*
Child watches television *(El niño mira televisión)* *(Ti moun nan gade televizyon)*		
Child eats meals with parent, guardian or other family members *(El niño comparte comidas con padre, el guardián o otros miembros de la familia)* *(Ti moun nan manje ak manman l ak papa l, ak moun ki responsab li a oswa ak lòt moun ki nan fanmi l)*		
Child looks at or reads books *(El niño mira o lee libros)* *(Ti moun nan gade oswa li liv)*		
Someone reads to the child *(Alguien lee al niño)* *(Yon moun ap li pou ti moun nan)*		
Child scribbles, draws, or writes *(Niño raya, dibuja, or escribe)* *(Ti moun nan ap fè madjigridji, fè desen oswa ekri)*		

Aftercare Services:
Before and aftercare services (wraparound services) may be available at your preschool. The hours are from 7:30 am – 8:30 am and 3:00 pm – 5:30 pm. The applications for wraparound services are located at your preschool of choice. When you go to the preschool to complete their required paperwork, do not forget to ask for the wraparound application. Thank you.

Cuido antes y despues de clase:

Cuido antes y despues de clase (Wraparound servicio) pueda que sea disponible en su Preescuela. Las horas son de 7:30 am – 8:30 pm y 3:00 pm – 5:30 pm. Las aplicaciones para este servicio estan disponiblse en su Preescuela de elección. Cuando vaya a la escuela para llenar los papeles necesarios, no se olvide de pedir la aplicación de Wraparound. Gracias.)

Sèvis avan ak apre lekol:

Sèvis avan ak apre lekol: kapab disponib nan lekòl matènèl timoun nan. Lè travay yo se 7:30 nan matin pou rive 8:30 nan matin ak 3:00 apren midi - 5:30 apren midi. Aplikasyon pou sèvis sa yo sitiye nan lekòl matènèl timoun ou an ke w chwazi. Lè ou ale nan lekòl matènèl la ranpli dokiman administratif ki nesesè yo, pa bliye mande pou yon aplikasyon pou sèvis avan ak apre lekol. Mèsi.

Orange Township Public Schools

Orange Early Childhood Center

Mrs. Jacquelyn Blanton, Principal

Gerald Fitzhugh, II, Ed.D.
Superintendent of Schools

HOME LANGUAGE SURVEY FORM

Student ID# _______________ Date ______________________

Student Name ______________________________ Date of Birth __________ 3yrs____ 4yrs____ 5yrs____

Address ___________________________________ Telephone# ______________________

Country of Origin (Parents) ____________________ Student's Country of Birth ______________________

1. What was the first language your child learned to speak? _________________________
2. If you speak a language other than English at home, what is it? ______________________________
3. How often do you use this other language? ( ) Always ( ) Sometimes ( ) Never
4. What language does your child speak most often? ____

____

Parent/Guardian Signature

ESPAÑOL

1. ¿Cual fue el primer idioma que su hijo/a aprendió a hablar? _____________________________
2. ¿Si usted habla otra idioma ademas del Inglés es su casa, cuál es? _____________________________
3. ¿Con que frecuencia habla usted este otro idioma? ( ) Siempre ( ) A veces ( ) Nunca
4. ¿Que idioma habla su hijo/hija más menudo? ____

____

Firma de Padre/Tutor

FRANCAIS

1. Quelle est la première langue que votre enfant a appris à parler? _____________________________
2. Si vous parlez chez vous une langue autre que l'Anglais veuillez l'indiquer sur cette ligne? ___________
3. Avec quelle frèquence parlez-vous cette langue? ( ) Toujours ( ) Parfois ( ) Jamai
4. Quelle langue parle votre enfante le plus souvent? __________________________

____

Signature du Parent/Tuteur

397 Park Avenue, Orange, NJ 07050
Phone: 973-677-4000, ext. 1903/1920 • Fax: 973-414-1283 • www.orange.k12.nj.us/Domain/528

Orange Township Public Schools

Orange Early Childhood Center

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WALKING PERMISSION SLIP
(PERMISO)

Dear Parent: (*Estimado Padre)*:

Each year we try to enrich your child's learning experience by exposing them to activities outside of the building. (*Cada año tratamos de enriquecer la experiencia de aprendizaje de niño exponiendolos a actividades fuera del edificio.)*

Although, you will be notified of upcoming activities, it has been proven beneficial to have your prior permission for walking trips on file. (*Aunque, usted sea notificado de actividades próximas, ha sido demostrado beneficioso tener su permiso previo para viajes caminantes en el archivo.*)

Respectfully, *(Respetuosamente,)*

Jacquelyn Blanton,
Principal of Orange Early Childhood Center

NOTE: ***Student may not participate without a signed permission slip***
(NOTA) ***(Estudiante no puede participar sin un firmado permiso)***

Please sign and return the bottom portion of this form to your child's teacher

My child ______________________________ has permission to participate in a walking
(Mi hijo) (*tiene permiso para participar en un viaje de estudio caminante*

Field trip with __________________________ for the _____________________ school year.

______________________ ______________________ ______________________
Parent Signature Teacher Name Date

Orange Township Public Schools

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PRESCHOOL SERVICES

The Early Childhood team from the Orange Board of Education will be working together with your child's preschool in the classrooms to promote quality education and provide services to the children and their families.

During the course of the school year, the Orange Board of education will be administering a hearing, vision and development screening to the preschool children. The results of this screening will be shared with you and the appropriate preschool staff. Check to indicate your permission for your child to participate.

_______________ The Orange Board of Education HAS permission to perform hearing, vision and developmental screening on my child.

_______________ The Orange Board of Education does NOT have permission to perform hearing, vision and developmental screenings on my child.

CHILD'S NAME: ____

PARENT/GUARDIAN SIGNATURE: ________________________________

DATE: ____________________

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EMERGENCY CONTACTS

Child's Name________________________________ ID#____________________

Parent/Guardian Name:____

School/Teacher Name:____

NAME:____

RELATIONSHIP TO CHILD:___________________________

ADDRESS:____

TELEPHONE NUMBER:

NAME:____

RELATIONSHIP TO CHILD:___________________________

ADDRESS:____

TELEPHONE NUMBER:

NAME:____

RELATIONSHIP TO CHILD:___________________________

ADDRESS:____

TELEPHONE NUMBER:

NAME:____

RELATIONSHIP TO CHILD:___________________________

ADDRESS:____

TELEPHONE NUMBER:

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Public Schools
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REGISTRATION OUTREACH SURVEY

- How did you find out about our district's preschool program?

Check all that apply:

Current Early Childhood Family

Friend

District Employee

Registration Flyer

District Website

District Elementary School

District Private Provider

Other Community Location

Other Source:________________________________ ________

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Orange Board Of Education
Department of Early Childhood Education
PARENT HEALTH HISTORY QUESTIONNAIRE

Student's Name ____________________ Date of Birth __________ Male ____ Female ____

Siblings name, age, school ____

Student resides with: Single parent ________ Both parents' ________ Grandparent(s) name ______________

Parent/Guardian Name ____

Pediatrician Name ____________________ Pediatrician Phone # ____________________

Pediatrician Address ____________________ Health Insurance: Yes _____ No _____

PREGNANCY HISTORY

Maternal illness ______________ Medications/Drug use______________ Normal pregnancy Yes _____ No _____

Number of week's premature ____ Complications ______________ Delivery: C-section _____ Vaginal _____

Birth Weight: _______ Babies' Health after birth: Normal _____ Remained in hospital for ______________

DEVELOPMENTAL HISTORY

Age when your child: walked ______; talked in 3-5 word sentences ______; intelligible speech Yes _____ No _____

toilet trained ____________________ Sits quietly while a story is read ____________________

Did your child receive Early Intervention Services such as occupational therapy, speech therapy, and/or physical therapy?

No ____ *Yes* ____ *If YES, who provided the services:* ______________________________

Parental concerns: ____

Does child snore: Yes ____ No ____; Blood Lead Tested: No ____ Yes ____ Date _____ Results/intervention_____

Visited Dentist: No _____ Yes _____ Date of visit ____________ Dental problems ______________

HEALTH CONDITIONS/PROBLEMS

	Child	Family		Child	Family
Asthma			Kidney/Urinary		
Diabetes			Lead Poison		
Cancer			Scarlet Fever		
Hearing			Seizure		
Heart Disease/murmur			Sickle Cell		
Hepatitis			TB Exposure		
Hypertension			Vision		

Other health concerns ____

Previous major illnesses, operations, or injuries______________________________

Hospitalized since birth? Date/Reason: ______________________________

Medications currently taking: None _______ Yes, describe ______________________________

ALLERGIES

Food ____________ Seasonal/Environmental ______________ Medication__________ Other _______

Epi-Pen: No ______ Yes _______, date/circumstances given ______________________________

Parent Signature ____________________ Pre-School Nurses Signature ____________________ Date ____________

BG/June 2012

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier

Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

CH-14 JUL 12 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider